DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 1 5

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 413

7. FEDERAL BUDGET IMPACT:
a. FFY 00 $179,673
b. FFY 01 $314,917

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATT 4.19A
1,2,3,4,5,6,9,9a,10,10a,10b,10c,11, 16b,17,18

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
1,2,3,4,5,6,9,9a,10,10a,10b,10c,11, 16b,17,18

10. SUBJECT OF AMENDMENT: Updates Hospital reimbursement principle description for current methodology, provides for trend factors for perdiem and trended costs, per diem reduction when rate exceeds costs, CON rate increases to State facilties use of twelve-month report when more then one report is received in calendar year provides for uninsured cost based on three year average with paymet at 77% of costs.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director

15. DATE SUBMITTED:
September 28, 2000

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
09/29/00

18. DATE APPROVED:
AUG 28 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/00

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE:
Acting
ARA for Medicaid and State Operations

23. REMARKS:
cc:
Martin
Vadner
Naite
CO

SPA CONTROL
Date Submitted 09/28/00
Date Received 09/29/00

FORM HCFA-179 (07-92)

Instructions on Back

STATE: Missouri

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Inpatient Hospital Services Reimbursement Plan

I. GENERAL REIMBURSEMENT PRINCIPLES

A. For inpatient hospital services provided for an individual entitled to Medicare Part A inpatient hospital benefits and eligible for Medicaid, reimbursement from the Missouri Medicaid program will be available only when Medicaid's applicable payment schedule amount exceeds the amount paid by Medicare. Medicaid's payment will be limited to the lower of the deductible and coinsurance amounts or the amount the Medicaid applicable payment schedule amount exceeds the Medicare payments. For all other Medicaid recipients, unless otherwise limited by rule, reimbursement will be based solely on the individual recipient's days of care (within benefit limitations) multiplied by the individual hospital's Title XIX per-diem rate. As described in paragraph V.D.2. of this rule, as part of each hospital's fiscal year-end cost settlement determination, a comparison of total Medicaid-covered aggregate charges and total Medicaid payments will be made and any hospital whose aggregate Medicaid per-diem payments exceed aggregate Medicaid charges will be subject to a retroactive adjustment.

B. The Title XIX reimbursement for hospitals located outside Missouri and for federally-operated hospitals in Missouri will be determined as stated in section (XIII) of this plan.

C. The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include per-diem payments, and disproportionate share payments; various Medicaid Add-On payments, as described in this plan; or a safety net adjustment, paid in lieu of Direct Medicaid Payments described in section XV and Uninsured Add-Ons described in subsection XVII.B. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Per-diem reimbursement - The per diem rate is established in accordance with section III.

2. Outpatient reimbursement is described in Attachment 4.19B.

3. Disproportionate share reimbursement - The disproportionate share payments described in sections XVI and XVII.B include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection VI.A.1 and 2 and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation are described in sections XVI, and XVII.B. These Safety Net and Uninsured Add-Ons are subject to federal limitation described in Omnibus Reconciliation Act of 1993 (OBRA 93) and section VI.E.

4. Medicaid Add-Ons– Medicaid Add-Ons are described in sections XV, XVIII and XX and are in addition to Medicaid per-diem payments. These payments are subject to the federal Medicare Upper Limit test.

5. Safety Net Adjustment– The payments described in subsection XVI are paid in lieu of Direct Medicaid Payments described in section X and Uninsured Add-Ons described in subsection XVII.B.

II. Definitions.

A. Allowable costs. Allowable costs are those related to covered Medicaid services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the Missouri Medicaid hospital provider manual and detailed on the desk reviewed Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item.

B. Bad debt - Bad debts should include the costs of caring for patients who have insurance but are not cover the particular services, procedures or treatment rendered. Bad debts should not include the cost of caring for patients whose insurance covers the given procedures but limits coverage. In addition, bad debts should not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

C. Base cost report–Desk-reviewed Medicare/Medicaid cost report from the fourth prior year. If a facility has more than one (1) cost report with periods ending in the fourth prior year, the cost report covering a full twelve (12) month period ending in the fourth prior year will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in the fourth prior year will be used.

Any changes to the desk reviewed cost report after the Division issues a final decision on assessment or payments based on the base cost report will not be included in the calculations.

D. Charity Care - results from a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

E. Contractual allowances--Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

F. Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report.

G. Disproportionate Share Reimbursement. The disproportionate share payments described in sections XVI and XVII.B include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection V.A.1 and 2 and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation are described in sections XVI, and XVII.B., of this regulation. These Safety Net and Uninsured Payments Add-Ons are subject to federal limitation as described in the Omnibus Reconciliation Act of 1993 (OBRA 93) and subsection VI.E.

H. Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification of the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

I. Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR part 405) as determined by the servicing fiscal intermediary based on yearly Hospital Cost Reports.

J. Non-reimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;

2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;

3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and

4. Costs or services or costs and services specifically excluded or restricted in this plan or the Medicaid hospital provider manual.

K. Per Diem rates. The per diem rates shall be determined from the individual hospital cost report in accordance with section III.

L. Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's Medicaid per-diem cost per day as determined in accordance with the general plan rate calculation from section III of this regulation using the base year cost report (by dividing allowable Medicaid inpatient costs by total Medicaid inpatient days, including nursery days).

M. Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

N. Children's hospital. An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) and which has designated in its licensor application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit as defined in 19 CSR 30-20.021(4)(F).

O. Hospital-sponsored primary care clinic–A clinic location which has met all of the following criteria:

1. The clinic shall not be physically located within a licensed hospital;

2. The clinic must be enrolled as a Medicaid provider;

3. The clinic is not certified by the Division of Health Standards and Quality, Health Care Financing Administration (HSQ/HCF) as being part of any hospital; and

4. The sponsoring hospital has completed and returned Hospital-Sponsored Primary Care Clinic Application to the Missouri Division of Medical Services by May 1, 1994, providing verification of the following:

A. The sponsoring hospital and the clinic are subject to the bylaws and operating decisions of the same governing body; or

B. The sponsoring hospital contributes at least five hundred thousand dollars ($500,000) annually towards the operation of the clinic.

P. FRA. The Federal Reimbursement Allowance, Appendix A, shall be an allowable cost.

III. Per-Diem Reimbursement Rate Computation. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with subsection XV.B. Each general plan (GP) hospital shall receive a Medicaid per-diem rate based on the following computation.

A. The per diem rate shall be determined from the 1995 cost report in accordance with the following formula:

$$\text{PER DIEM} = \frac{(\text{OC} * \text{TI})}{\text{MPD}} + \frac{\text{CMC}}{\text{MPDC}}$$

1. OC - The operating component is the hospital's TAC less CMC;

2. CMC - The capital and medical education component of the hospital's TAC;

3. MPD - Medicaid inpatient days;

4. MPDC - MPD as defined in III.A.3. with a minimum utilization of sixty percent (60%) as described in paragraph V.C.4.;

5. TI -Trend Indices. The trend indices are applied to the OC of the per-diem rate. The trend indices for SFY 95 is used to adjust the OC to a common fiscal year end of June 30;

6. TAC - Allowable inpatient routine and special care unit expenses, ancillary expenses and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The per diem shall not exceed the average Medicaid inpatient charge per diem as determined from the base year cost report and adjusted by the TI.

8. The per diem shall be adjusted for rate increases granted in accordance with subsection V.F., for allowable costs not included in the base year cost report

B. Trend Indices (TI). Trend indices are determined based on the four (4) quarter average DRI Index for DRI-Type Hospital Market Basket as published in Health Care Costs by DRI/McGraw-Hill for SFY 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on the CPI Hospital index as published in Health Care Cost by DRI/McGraw-Hill for each SFY starting with SFY99.

1. The TI are –

A. State Fiscal Year 1994 - 4.6%.,
B. State Fiscal Year 1995 - 4.45%;
C. State Fiscal Year 1996 - 4.575%;
D. State Fiscal Year 1997 - 4.05%;

E. State Fiscal Year 1998-3.1%;
F. State Fiscal Year 1999-3.8%
G. State Fiscal Year 2000-4.0%
H. State Fiscal Year 2001-4.6%

2. The TI for SFY 96 through SFY 98 are applied as a full percentage to the OC of the per-diem rate and for SFY '99 the OC of June 30, 1998 rate shall be trended by 1.2% and for SFY 2000 the OC of June 30, 1999 rate shall be trended by 2.4%. The OC of the June 30, 2000 rate shall be trended by 1.95%.

IV. Per-diem Rate New Hospitals.

A. Facilities Reimbursed by Medicare on a Per-Diem basis. In the absence of adequate cost data, a new facility's Medicaid rate may be its most current Medicare rate on file for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

B. Facilities Reimbursed by Medicare on a DRG Basis. In the absence of adequate cost data, a new facility's Medicaid rate may be one hundred twenty percent (120%) of the average-weighted, statewide per-diem rate for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for the third fiscal year will be the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

V. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon request of the hospital and the approval of the Missouri Division of Medical Services when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and post marked prior to the first day of the sixth (6th) month following the hospital's fiscal year end.

*Substitute per letter dated 6/8/01 *

C. New, Expanded, or Terminated Services

1. A hospital, at times, may offer, to the public, new or expanded services for the provision of allowable inpatient or outpatient services which require Certificate of Need (CON) approval or permanently terminate a service. For a state hospital, i.e., one owned or operated by the Board of Curators as provided for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, the state hospital may offer new or expanded inpatient services to the public provided it receives legislative appropriations for the project and the project meets the CON costs threshold. Within six (6) months after this event, the hospital must submit a request for rate reconsideration with a budget which shall take into consideration new, expanded or terminated services. Since a state hospital is not subject to the CON approval process, a state hospital will have six (6) months after the effective date of this amendment to file a budget for CON type projects completed after its base year cost report and will then have six (6) months after the completion of the new or expanded service is offered to the public. The budgets will be subject to desk review and audit. Upon completion of the desk review, reimbursement rates may be adjusted, if indicated. Failure to submit a request for rate reconsideration and budget within the six (6) month period shall disqualify the hospital from receiving a rate increase. Failure to submit a request shall not prohibit the division from reducing the rate in the case of a terminated service.

2. Failure to submit a budget concerning terminated services may result in the imposition of sanctions as described in 13 CSR 70-3.030.

3. Rate adjustments due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense and annual additional operating costs) multiplied by the ratio of total inpatient costs (less swing bed cost) to total hospital cost as submitted on the most recent cost report filed with the agency as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days.

4. Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the days, including neonatal units, are less than sixty percent (60%), the sixty percent (60%) number plus newborn days will be used to determine the rate increase. This computation will apply to capital costs only.

Substitute per letter dated 6/8/01

D. Audits

1. A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:

   (a) Desk review all hospital cost reports;

   (b) Determine the scope and format for on-site audits;

   (c) Perform field audits when indicated in accordance with Title XIX principles; and

   (d) Submit to the state agency the final Title XVIII cost report with respect to each such provider.

2. The state agency shall review audited Medicaid-Medicare cost reports for each hospitals fiscal year in accordance with Appendix B.

E. Adjustments to Rates

The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the Medicaid agency from imposing any sanctions authorized by any statute or regulation;

2. When rate reconsideration is granted in accordance with subsection V.F.;

3. When the Medicare per-diem rate is changed by the servicing fiscal intermediary based on a new audit finding for the base year. This adjustment may be applied and effective no earlier than the first day of the month following notification by the Division of Medical Services; and

4. When a hospital documents to the Division of Medical Services, a change in its status from nonprofit to proprietary, or from proprietary to nonprofit, its direct Medicaid payments for the State Fiscal Year will be adjusted to take into account

any change in its Medicaid inpatient allowable costs due to the change in its property taxes. The Medicaid share of the change in property taxes will be calculated for the State Fiscal Year in which the change is reported by multiplying the increase or decrease in property taxes applicable to the current State Fiscal Year by the ratio of allowable Medicaid inpatient hospital costs to total costs of the facility. (For example, if the property taxes are assessed starting January 1 for the calendar year, then one half of the calendar year property taxes will be used to calculate the additional inpatient direct Medicaid payments for the period of January 1 to June 30.

F. Rate Reconsideration

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base period described in subsection III.A.. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division of Medical Services' final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the Medicaid Agency:

   (a) Substantial changes in or costs due to case mix; or

   (b) New, expanded or terminated services as detailed in subsection V.C.

(c) When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance.

3. The following will not be subject to review under these procedures:

   (a) The use of Medicare standards and reimbursement principles;

   (b) The method for determining the trend factor;

   (c) The use of all-inclusive prospective reimbursement rates; and

   (d) Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program.

Substitute per letter dated 6/8/01

4. As a condition of review the Missouri Division of Medical Services may require the hospital to submit to a comprehensive operational review. Such review will be made at the discretion of the State Medicaid Agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the Missouri Division of Medical Services and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the adjustment is necessary, proper and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified of the Agency's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60)-day period shall be grounds for denial of the request. If the state does not respond within the sixty (60)-day period, the request shall be deemed denied.

G. Sanctions

Sanctions may be imposed against a provider in accordance with applicable state and federal regulations.

VI. Disproportionate Share

A. Impatient hospital providers may qualify as a Disproportionate Share Hospital based on the following criteria. Hospitals shall qualify as Disproportionate Share Hospitals for a period of only one (1) state fiscal year and must re-qualify at the beginning of each state fiscal year to continue their disproportionate share classification.

1. If the facility offered non-emergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to those services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a Metropolitan Statistical Area, as defined by the federal executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer non-emergency obstetric services as of December 21, 1987;

2. As determined from the fourth prior year desk reviewed cost report, the facility must have either–

(a) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean Medicaid inpatient utilization rate for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded.

$$MIUR = \frac{TMD}{TNID}$$

or;

(b) A low income utilization rate in excess of twenty-five percent (25%).

(1) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

a. Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts etc.) For patient services plus the cash subsidies, and;

b. The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party or personal resources) less cash subsidies directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a State Plan.

$$LIUR = \frac{TMPR \div CS}{TNR \div CS} \div \frac{CC - CS}{THC}$$

3. As determined from the fourth prior year desk-reviewed cost report, the hospital has either -

(a) An unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in paragraph (6) (A) 2.; or

(b) The hospital ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days.

(c) The facility operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of the percentage identified in 13 CSR 70-15.010 (6) as reported or verified by the division from the fourth prior year cost report;

4. As determined from the fourth prior year desk-reviewed cost report,

   (a) The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty inpatient beds; or

   (b) The acute care hospital has an unsponsored care ratio of at least sixty-five (65%) and is licensed for fifty inpatient beds or more and has an occupancy rate of more than forty percent (40%); or

   (c) The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo and the Missouri Rehabilitation Center created by Chapter 199, RSMo or their successors.

   (d) The Hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

5. As determined from the fourth prior year desk reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.

B. Those hospitals which meet the criteria established in paragraphs VI.A.1., 2. and 4. shall be deemed Safety Net Hospitals. Those hospitals which meet the criteria established in VI.A.1. and 3. shall be deemed First Tier DSH. Those hospitals which meet only the criteria established in paragraphs VI.A.1., 2., or 5., shall be deemed Second Tier DSH.

C. A hospital not meeting the requirements in subsection VI.A., but has a Medicaid inpatient utilization percentage of a least one percent (1%) for Medicaid eligible recipients may at the option of the state be deemed a Disproportionate Share Hospital (DSH). These facilities may receive only the DSH payments identified in section XVII.

(b) For hospitals that meet the requirements in paragraphs VI.A.1., VI.A.2. and VI.A.4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year, based on the determination of the Division of Medical Services exercising its sole discretion as to which report is most representative of costs incurred. For hospitals that meet the requirements in paragraphs VI.A.1., and VI.A.3., of this rule (first tier Disproportionate Share Hospitals), the base year operating costs shall be based on the third prior year cost report. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve-month cost report and a partial year cost report, its base period cost report for that year will be the twelve-month cost report.

(c) The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment and the poison control costs computed in paragraphs XV.B.1., 3., 4., and 5.

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization as identified in paragraph V.C.4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated Medicaid patient days for the SFY.

4. The utilization adjustment cost is determined by estimating the number of Medicaid inpatient days the hospital will not provide as a result of the MC + Health Plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated Medicaid days for the current SFY to arrive at the Medicaid utilization adjustment.

5. The poison control cost shall reimburse the hospital for the prorated Medicaid managed care cost. It will be calculated by multiplying the estimated Medicaid share of the poison control costs by the percentage of MC+ recipients to total Medicaid recipients.

C. SFY 99 Direct Medicaid Payments starting January 1, 1999 will be determined by subtracting the Add-On payments made for unreimbursed Medicaid costs between July 1, 1998 and December 31, 1998 from the SFY 99 unreimbursed Medicaid costs calculated in subsection XV.B. The difference in the unreimbursed Medicaid costs will be prorated over the remainder of the SFY 99 and paid directly to the hospitals.

XVI. Safety Net Adjustment. A Safety Net Adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph VI.A.4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

A. The safety net adjustment for facilities not operated by the Department of Mental Health primarily for the care and treatment of mental disorders shall be computed in accordance with the Direct Medicaid Payment calculation described in section XV and the Uninsured Add-Ons calculation in subsection XVII.B. regulation. The safety net adjustment will include the last three quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

B. The safety net adjustment for facilities operated by the Department of Mental Health primarily for the care and treatment of mental disorders shall be computed in accordance with the Direct Medicaid Payment calculation described in section XV and one hundred percent (100%) of the Uninsured costs calculation described in subsection XVII.B. of this regulation. The safety net adjustment will include the last three quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

C. The state share of the safety net adjustment for hospitals described in subparagraphs VI.A.4(a) and VI.A.4.(d) shall come from cash subsidy (CS) certified by the hospitals. If the aggregate CS is less than the state match required, the total aggregate safety net adjustment will be adjusted downward accordingly, and distributed to the hospitals in the same proportions as the original safety net adjustments.

XVII. In accordance with state and federal laws regarding reimbursement of unreimbursed Medicaid costs and the costs of services provided to uninsured patients, reimbursement for state fiscal year 2001 (July 1 - June 30) shall be determined as follows:

A. Medicaid Add-Ons for Shortfall

The Medicaid Add-On for the period of July, 1998 to December 31, 1998 will be based on fifty percent (50%) of the unreimbursed Medicaid costs as calculated for SFY 1998.

B. Uninsured Add-Ons

The hospital shall receive seventy-six percent (76%) of the Uninsured costs prorated over the SFY. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive seventy-seven percent (77%) of its uninsured costs prorated over the SFY. The uninsured Add-On will include:

1. The Add-On payment for the cost of the uninsured will be based on a three-year average of the fourth, fifth and sixth prior base year cost reports. For any hospital that has both a twelve-month cost report and a partial-year cost report, its base period cost report for that year will be the twelve-month cost report. The Add-On payment for the cost of the uninsured is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the uninsured is then trended to the current year using the trend indices in subsection III.B.. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment;and

2. An adjustment to recognize the Uninsured patients share of the FRA assessment not included in the desk review cost. The FRA assessment for Uninsured patients is determined by multiplying the current FRA assessment by the ratio of uninsured days to total inpatient days from the base year cost report;

3. The difference in the projected General Relief per-diem payments and trended costs for General Relief patient days; and

4. The increased costs per day resulting from the utilization adjustment in subsection XV.B. is multiplied by the estimated uninsured days.

Substitute per letter dated 6/8/01

Attachment A

CALCULATION OF MEDICARE UPPER LIMIT TEST

The Medicare Upper Limit test is calculated using the following methodology.

- The 1993 operating cost per day is calculated by dividing the 1993 operating cost by 1993 Medicaid discharges.
- The 1993 per discharge amount is trended forward using the full TEFRA Medicare trend indices to current SFY.
- The trended per discharge amount is multiplied by the Medicaid discharges from the 1997 cost report (latest information available) to arrive at the Medicaid operating cost.
- Capital, Medical Education and CNRA costs from the 1997 cost report are added to the Medicaid operating cost and the sum is divided by 1997 Medicaid patient days to get a cost per day.
- The cost per day is multiplied by the current estimated FFS Medicaid patient days to which we add the FRA assessment associated with Medicaid FFS days to arrive at the Upper Limit Payment using Medicare TEFRA principles.

The Medicaid payments compared to the Upper Limit Payments are calculated using the following methodology.

- The per diem rate for the current fiscal year is multiplied by the estimated FFS Medicaid patient days for the SFY to arrive at Medicaid claim payments.
- We add the Direct Medicaid payments for FFS recipients including the additional capital cost for excluding the minimum utilization, the FRA assessment associated with Medicaid FFS days and the difference between the per diem rate and the trended cost per day to arrive at total Medicaid payments subject to the upper limit.

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